Glendora Wellness
MEDICAL WEIGHT LOSS CENTER

HIPAA Medical Information Release Form

Name: _____ **Date of Birth: ____/____/_____**

Release of Information

[ ] I authorize the release of information, including but not limited to, the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse/Partner: _____

[ ] Child(ren): _____

[ ] Other: _____

[ ] Information is not to be released to anyone.

*This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell number

If unable to reach me, I give my permission to: [ ] leave a detailed message.

[ ] leave a message asking me to return your call.

[ ] _____

The best time to reach me is (day) _____ between (time) _____.

Signed: _____ Date: ___/___/_____

Witness: _____ Date: ___/___/_____